Authorization

[Refer to WAC 388-531-0200]

Limitation Extensions and Expedited Prior Authorization numbers do not override the client's eligibility or program limitations. Not all categories of eligibility receive all services. For Example: Therapies are not covered under the Medically Indigent Program (MIP).

MAA's authorization requirements can be met by using the following authorization processes:

1. Written or fax authorization; and
2. Expedited prior authorization (EPA).

These authorization procedures do not apply to out-of-state care. Out-of-state care is not covered (see page A2). Out of state hospital admissions are not covered unless they are emergency admissions.

Limitation Extensions (LE)

What is a Limitation Extension?

Limitation extension (LE) is authorization for cases when a provider can verify that it is medically necessary to provide more units of service than allowed in MAA's billing instructions and Washington Administrative Code (WAC).

How do I get LE authorization?

Some LE authorizations may be obtained by using the Expedited Prior Authorization process. Refer to the EPA section (page I7) for criteria. If the EPA process is not applicable, limitation extensions may be obtained using the written/fax authorization process (see below).

Written/Fax Authorization

What is written/fax authorization?

Written or fax authorization is a paper authorization process available to providers when expedited prior authorization has not been established or the expedited prior authorization criteria is not applicable.

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Which services require written/fax authorization?

All services noted in WAC and billing instructions as needing prior authorization require written or fax authorization.

EXAMPLES of services that require written/fax authorizations are:

Code	Procedure
0009T-0013T	New technology CPT Category III codes
54416-54417	Repair of Penile Implant
61885, 61886, 64573 and 64585	Vagus Nerve Stimulator Insertion, Removal, or Revision
66930 & A9900	Cochlear Implantation and External Replacement Parts
67909	Reduction of Overcorrection of Ptosis
55873	Cryosurgical Ablation of the Prostate
69714-69718	Osseointegrated Implants
78810	Tumor imaging (PET)
88380	Microdissection
95965-95967	Magnetoencephalography (MEG)
G0030-G0047	Myocardial perfusion imaging (PET)
J2020	Linezolid injection
J2940	Somatrem injection
J2941	Somatropin injection
J7340	Metobolic active D/E tissue
S0093	Morphine 500 mg
99221-99223	Inpatient Acute PM&R
	Services that have published EPA criteria ✓ Only when the client's situation does not meet MAA's published EPA criteria, the service is medically necessary/medically appropriate in accordance with established criteria and there is no option to create an EPA number that indicates that the medical appropriateness is documented in the medical record.

How do I obtain written/fax authorization?

Send or fax your request to:

MAA – Division of Medical Management
Attn: Medical Request Coordinator
PO Box 45506
Olympia, WA 98504-5506
FAX: (360) 586-1471

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Fax\Written Request Basic Information

Provider Information

Name _____ Provider #: _____

Phone _____ Fax: _____

Client Information

Name _____ PIC# ____-____-____

ie (AB-122300-SMITH-A)

Service Request Information

Description of service being requested: _____

_____

Procedure Code _____ Number units requested _____ number units used this year _____

Medical Information

Dates of injury or illness _____

Diagnosis code _____ Diagnosis name _____

Place of service _____

How will approving this request change the course of treatment?

_____

_____

Goal of treatment? _____

_____

_____

What is the clinical justification for this request (if not addressed above?)

_____

_____

_____

Please send in any necessary additional documentation with your request to:

Fax: **360-586-1471** or mail to: Medical Request Coordinator
MAA\DMM (previously DHSQS)
PO Box 45506
Olympia, WA 98504-5506

Expedited Prior Authorization (EPA)

Expedited prior authorization does not apply to out-of-state care. Out-of-state care is not covered (see page A2). Out-of-state hospital admissions are not covered unless they are emergency admissions.

What is the EPA process?

MAA's EPA process is designed to eliminate the need for written authorization. The intent is to establish authorization criteria and identify these criteria with specific codes, enabling provider to create an "EPA" number when appropriate.

How is an EPA number created?

The first six digits of the EPA number must be **870000**. The last 3 digits must be the code number of the diagnostic condition, procedure, or service that meets the EPA criteria. Enter the EPA number on the billing form in the authorization number field, or in the *Authorization* or *Comments* field when billing electronically.

Example: The 9-digit authorization number for a brain MRI in a client with suspected brain tumor and new onset of unexplained seizures would be **870000303** (**870000** = first six digits of all expedited prior authorization numbers, **303** = last three digits of an EPA number, and they indicate both the diagnostic condition, procedure, or service and indicate which criteria the case meets).

Note: When the client's situation does not meet published criteria and there is no option to create an EPA number that indicates the medical necessity is documented in the client's medical record, prior authorization is necessary.

If there is an option to create an EPA number based on the medical necessity being documented in the medical record, and medical necessity can not be documented, the service is not covered.

Expedited Prior Authorization Guidelines

A. Diagnoses

Only diagnostic information obtained from the hospital or outpatient chart may be used to meet conditions for EPA. Claims submitted without the appropriate diagnosis, procedure code or service as indicated by the last three digits of the EPA number will be denied.

B. Documentation

The billing provider must have documentation of how expedited criteria was met, and have this information in the client's file available to MAA on request. When care is received in the hospital, the documentation of how the expedited prior authorization criteria were met must also be in the hospital record.

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Which services require EPA?

EPA is required for services noted in MAA's billing instructions and WAC as needing expedited prior authorization.

Examples of services requiring EPA:

- **Hysterectomies** (CPT: 51925, 58550, 58551, 58150-58285, 59525)
  Note: CPT codes 58152 and 58267 must meet guidelines for both hysterectomies and bladder repair.

  Exceptions: MAA does not require EPA for clients 46 years of age and older; **and/or** clients that have been diagnosed with cancer(s) of the female reproductive organs (ICD-9-CM: 179-184.9, 198.6, 198.82, 233.1-233.3, 236.0-236.3, 239.5).

- **Bladder Repairs** (CPT: 51840-51845, 57288-57289, 58152, and 58267)
  Note: Bladder repairs are only allowed for client's with a diagnosis of stress urinary incontinence (ICD-9-CM: 625.6, 788.30-788.39)

- **Reduction Mammoplasties** (CPT: 19318)
  Note: Reduction Mammoplasties are only allowed with ICD-9-CM diagnosis codes 611.1 and 611.9.

- **Mastectomies for Gynecomastia** (CPT: 19140)
  Note: Mastectomies for Gynecomastia are only allowed with ICD-9-CM diagnosis codes 611.1 and 611.9.

- **Visual Exams, Dispensing and Fitting Fees, Frames, Glasses, and Lenses**
  When in excess of MAA establish limitations.

- **Blepharoplasties** (CPT 67901-67908) **and Strabismus Surgery** (CPT 67311-67340)
  Clients 18 years of age and older.

- **Physical and Occupational Therapy**
  When in excess of MAA establish limitations.

- **Outpatient PET Scans** (HCPCS G0125, G0210-G0218, G0220-G0234, G0253-G0254)
  Exception: G0030-G0047 still require written/fax prior authorization.

See next page for more…

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- **Outpatient MRIs and MRAs**

- **Inpatient Medical Admits** (CPT: 99221-99223)
  Note: MAA requires EPA when the diagnosis is in the following chart and the client is seven years of age and older:

Description	ICD-9-CM Diagnosis Code(s)
Abdominal Pain	789-789.09
Back Pain	724-724.6, 724.8-724.9, 846-847.9
Cellulitis	681-681.9, 682, 682.2-682.9
Chronic pancreatitis	577-577.1
Constipation	560.3, 560.39, 564-564.9
Dehydration; Disorders of Electrolyte Imbalance	276-276.6, 276.8-276.9
Headache	784.0
Gastritis/Gastroenteritis	535-535.6, 558-558.9
Migraine Headache	346-346.9
Nausea/vomiting	536.2; 787-787.03
Malaise & Fatigue	780.7-780.79
Painful Respiration	786.52
Related general symptoms	780, 780.4, & 780.9
Respiratory abnormality	786.09

Short stay admissions (less than 24 hours) do not require authorization – use CPT codes 99218-99220 for admits, and 99217 for discharge.

Clients six years of age and younger do not require prior authorization for inpatient medical admits. However, these admits must be medically appropriate in accordance with MAA's established criteria.

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Washington State
Expedited Prior Authorization Criteria Coding List

Code	Criteria

Abdominal Hysterectomy
CPT: 58150, 58180, 58200, 58210

101 Diagnosis of **abnormal uterine bleeding** in a client 30 years of age or older with two or more of the following conditions:

1) Profuse uterine bleeding requiring extra protection more than eight days a month for more than 3 months.
2) Documented hct of <30 or hgb <10
3) Documented failure of conservative care i.e.: d&c, laparoscopy, or hormone therapy for at least three months.

102 Diagnosis of **fibroids** for any one of the following indications in a client 30 years of age or older:

1) Myomata associated with uterus greater than 12 weeks or 10cm in size
2) Symptomatic uterine leiomyoma regardless of size with profuse bleeding more than eight days a month for three months requiring extra protection or documented hct <30 or hgb <10
3) Documented rapid growth in size of uterus/myomata by consecutive ultrasounds or exams.

103 Diagnosis of **symptomatic endometriosis** in a client 30 years of age or older with the following:

1) Significant findings per laproscope and
2) Unresponsiveness to 3 months of hormone therapy or cauterization.

104 Diagnosis of **chronic advanced pelvic inflammatory disease** in a client 30 years of age or older with infection refractory to multiple trials of antibiotics

Code	Criteria

Vaginal Hysterectomy
CPT: 58270-58285, 58550-58551, 58260-58263

111 Diagnosis of **abnormal uterine bleeding** in a client 30 years of age or older with two or more of the following conditions:

1) Profuse uterine bleeding requiring extra protection more than eight days a month for more than 3 months.
2) Documented hct of less than 30 or hgb less than 10.
3) Documentation of failure of conservative care, i.e.: d&c, laparoscopy, or hormone therapy for at least three months.

112 Diagnosis of **fibroids** for any one of the following indications in a client 30 years of age or older:

1) Myomata associated with uterus greater than 12 weeks or 10cm in size
2) Symptomatic uterine leiomyoma regardless of size with profuse bleeding more than eight days a month for three months requiring extra protection or documented hct less than 30 or hgb less than 10
3) Documented rapid growth in size of uterus/myomata by consecutive ultrasounds or exams.

113 Diagnosis of **symptomatic endometriosis** in a client 30 years of age or older with the following:

1) Significant findings per laproscope; and
2) Unresponsiveness to 3 months of hormone therapy or cauterization.

114 Diagnosis of **chronic advanced pelvic inflammatory disease** in a client 30 years of age or older with infection refractory to multiple trials of antibiotics.

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Code	Criteria	Code	Criteria

115 Diagnosis of **symptomatic pelvic relaxation** (in a client 30 years of age or older) with a 3rd degree or greater uterine prolapse (at or to vaginal introitus).

Bladder Neck Suspension

CPT: 51840-51845, 57288-57289

201 Diagnosis of **stress urinary incontinence** with all of the following:

1) Documented urinary leakage severe enough to cause the client to be pad dependent; and
2) Surgically sterile or past child bearing years; and
3) Failed conservative treatment with one of the following: bladder training or pharmacologic therapy; and
4) Urodynamics showing loss of ureterovescical angle or physical exam showing weak bladder neck and
5) Recent gynecological exam for coexistent gynecological problems correctable at time of bladder neck surgery.

Hysterectomy With Colopourethrocystopexy

CPT: 51925, 58152, and 58267

221 Diagnosis of **Abnormal uterine bleeding and Stress Urinary Incontinence**-meeting criteria 101 or 111 and 201.

222 Diagnosis of **Fibroids and Stress Urinary Incontinence**-meeting criteria 102 or 112 and 201.

223 Diagnosis of **Symptomatic Endometriosis and Stress Urinary Incontinence**-meeting criteria 103 or 113 and 201.

224 Diagnosis of **Chronic Pelvic Inflammatory Disease and Stress Urinary Incontinence** - meeting criteria 104 and 114.

225 Diagnosis of **Symptomatic Pelvic Relaxation and Stress Urinary Incontinence -** meeting criteria 115 and 201.

226 **Hysterectomy not requiring authorization** and **Stress Urinary Incontinence** meeting criteria 201.

Other Hysterectomies and/or Bladder Repairs With Diagnosis Of 625.6 Or 788.30-788.39

CPT: 58150, 58180, 58200, 58210, 58240, 51840-51845, 57288-57289, 51925, 58152, 58550, 58260-58263, 58267, 58270, 58276, 58280, 58285, and 59525

230 Hysterectomies and/or bladder repairs not meeting expedited criteria, but medically necessary/medically appropriate in accordance with established criteria. Evidence of medical appropriateness must be clearly evidenced by the information in the client's medical record.

Reduction Mammoplasties/ Mastectomy For Gynecomastia

CPT: 19318, 19140

241 Diagnosis for **hypertrophy of the breast** with:

1) Photographs in client's chart, and
2) Documented medical necessity including:
   a) Back, neck, and/or shoulder pain for a minimum of one year, directly attributable to macromastia, and
   b) Conservative treatment not effective; and
3) Abnormally large breasts in relation to body size with shoulder grooves, and
4) Within 20% of ideal body weight, and
5) Verification of minimum removal of 500 grams of tissue from each breast.

242 Diagnosis for **gynecomastia**:

1) Pictures in clients' chart, and
2) Persistent tenderness and pain, and
3) If history of drug or alcohol abuse, must have abstained from drug or alcohol use for no less than one year.

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Code	Criteria

Other Reduction Mammoplasties/ Mastectomy For Gynecomastia With Diagnosis Of 611.1 Or 611.9

250 Reduction mammoplasty or mastectomy, not meeting expedited criteria, but medically necessary/medically appropriate in accordance with established criteria. Evidence of medical appropriateness must be clearly evidenced by the information in the client's medical record.

Brain Magnetic Resonance Imaging (MRI)
CPT: 70544-70546, 70551-70553

301 Suspected diagnosis of **acoustic neuroma** if one of the following:

1) Unilateral sensorineural hearing loss per audiogram, or
2) Decreased discrimination score that is out of proportion to amount of hearing loss per ENT evaluation, or
3) Positive or inconclusive computed tomography with a need for clearer definition, and one of the above.

302 Suspected diagnosis of **pituitary tumor** with any two of the following:

1) Galactorhea
2) Pre menopausal amenorrhea
3) Elevated prolactin level **(females must have negative pregnancy test)**
4) Positive or inconclusive computed tomography and one of the above with a need for clearer definition

303 Suspected diagnosis of **brain tumor** with any one of the following:

1) Unexplained new onset seizure
2) Objective evidence of increased intracranial pressure
3) Positive or inconclusive computed tomography with a need for clearer definition, and one of the above.

304 **Follow up** of **brain tumor** if done at:

1) Three months from the date of last MRI and in the first two years of diagnosis in any of the following cases:
   a) Tumor is currently being treated
   b) Post treatment
   c) With documented changes in tumor size or
2) Six months from the date of last MRI and in the second to fifth years of diagnosis or
3) One year from the date of last MRI in the sixth to tenth year of diagnosis or
4) Symptoms of recurrence in a client that would be treated aggressively

305 Suspected diagnosis of **multiple sclerosis** with three or more of the following objective findings:

1) Progressive weakness or decreased sensation in extremities
2) Difficulty word finding
3) Diplopia
4) Vertigo or vertigo nystagmus
5) Optic neuritis
6) Facial weakness
7) Positive Lhermitte's sign

Note to 305: Only for initial diagnosis, not as a follow-up.

306 Suspected diagnosis of **toxoplasmosis versus lymphoma versus progressive multifocal leukoencephalopathy** in an HIV positive client with:

1) Central nervous system changes **in a client that would be aggressively treated**.
2) Positive or inconclusive computed tomography with a need for clearer definition **in a client that would be aggressively treated**

307 Diagnosis of **breast cancer** for staging as part of PSCT or BMT protocol.

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Code	Criteria

308 Suspected diagnosis of **seizure disorder** with unexplained onset of seizures.

309 Diagnostic evidence of **refractory seizures**, as part of preoperative work up.

Lumbar MRI

CPT: 72148, 72149, 72158

311 Suspected diagnosis of **Herniated Nucleus Pulposus or Tumor** in a surgical candidate with two or more of the following objective findings:

1) New onset of bowel or bladder incontinence not related to known diagnosis;
2) Asymetric or bilaterally absent tendon reflexes in the lower extremity (patella/achilles);
3) Visible atrophy of key muscle groups of lower extremities;
4) Decrease sensation in a dermatomal pattern not previously attributed to another diagnosis;
5) Significant weakness of key muscle groups of either or both lower extremity; or
6) Positive study indicating definitive nerve root compression.

312 Suspected diagnosis of **tumor or abscess** with a bone scan or x-ray suspicious for same.

Cervical MRI

CPT: 72141, 72142, 72156

321 Suspected **herniated nucleus pulposa or tumor** with two or more of the following objective findings:

1) Decreased tricep, bicep, or brachial radialis reflex;
2) Decrease sensation in upper extremities in a dermatomal distribution;
3) Decreased muscle strength of upper extremities and limitation of movement;
4) Upper extremity muscle atrophy;
5) Hyperreflexia;
6) Positive babinski in non-infant; or
7) Studies showing definitive nerve root compression, and ruling out carpal tunnel syndrome.

Note to 321: Carpal tunnel syndrome must be ruled out prior to cervical MRI when symptoms indicate possible carpal tunnel syndrome.

322 Suspected diagnosis of **tumor or abscess** with a bone scan or xray suspicious for same.

Thoracic MRI

CPT: 72146, 72147, 72157

331 Suspected diagnosis of **tumor or abscess**:

1) With a bone scan or x-ray suspicious for same, or
2) Evidence of myelopathy, such as hyperreflexia, positive babinski in a non-infant, ataxia, etc.

Pelvic MRI

CPT: 72195-72197

341 Suspected diagnosis of **avascular necrosis** with:

1) Pain in the hip radiating to the knee and
2) A history of one of the following:
   a) Previous trauma
   b) Intracapsular fractures
   c) Alcoholism
   d) High dose steroid use
   e) Air embolism from diving, or
   f) Hemoglobinopathies

342 Suspected diagnosis of **tumor or abscess** with a bone scan or x-ray suspicious for same.

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Code	Criteria	Code	Criteria

Knee MRI
CPT: 73721

351 Suspected **anterior cruciate ligament tear** when xray is negative for bony abnormalities, and the intent is to treat aggressively with at least three of the following:

1) History of hyperextension injury with immediate swelling, and complaints of giving way or buckling, or
2) Four or more weeks of conservative care, or
3) Current exam with the following findings: hemarthrosis and\or positive Lockman's and\or positive pivot shift, or
4) MRI is necessary to choose treatment option(s).

352 Suspected **posterior cruciate ligament tear** when xray is negative for bony abnormalities, and the intent is to treat aggressively with at least two of the following:

1) History of direct blow to anterior tibia or forced hyperflexion, or
2) Four or more weeks of conservative care, or
3) Current clinical with one or more positive findings: positive drawers, test positive tibial sag.

353 Suspected **meniscal tear** when xray is negative for bony abnormalities, and the intent is to treat aggressively with at least two of the following:

1) History of twisting injury with subsequent catching, locking, and swelling, or
2) Four or more weeks of conservative care, or
3) One or more of the following exam findings: joint line tenderness, positive McMurrays.

Upper Extremity MRI
CPT: 73218-73223

361 Suspected diagnosis of **tumor or abscess** with a bone scan or x-ray suspicious for same.

Lower Extremity MRI
CPT: 73718-73723

371 Suspected diagnosis of t**umor or abscess** with a bone scan or x-ray suspicious for same.

Abdominal MRI
CPT: 74181-74183

381 Suspected diagnosis of **tumor or abscess** with both of the following:

1) Ultrasound positive for mass on the kidney, pancreas, or liver, and
2) Objective evidence of poor renal function.

Other MRI/MRA
All other covered MRI/MRA

390 MRIs/MRAs not meeting expedited criteria, but medically necessary/medically appropriate in accordance with established criteria. Evidence of medical appropriateness must be clearly evidenced by the information in the client's medical record.

Note: If billing for more than one MRI/MRA for the same reason, use criteria code 390.

Note: If billing for more than one MRI/MRA for different reasons, build two separate expedited prior authorization numbers.

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Code	Criteria	Code	Criteria

PET Scan
HCPCS code: G0125
DX: 235.7, 793.1

382 PET imaging regional or whole body when the client has a pulmonary nodule.

PET Scans
HCPCS codes: G0210, G0213, G0216, G0220

383 PET Imaging whole body to diagnose; lung cancer (non small cell), colorectal cancer, melanoma, or lymphoma **when at least one of the following is true:**

1) The PET results may assist in avoiding an invasive diagnostic procedure; or
2) The PET results may assist in determining the optimal anatomical location to perform an invasive diagnostic procedure.

PET Scans
HCPCS codes: G0211, G0214, G0217, G0221
DX: 162.0-162.9, 153.0-154.8, 172.0-172.9, 190.9, 200.00-202.28

384 PET Imaging whole body for initial staging of; lung cancer (non-small cell), colorectal cancer, melanoma, or lymphoma **when one of the following is true:**

1) The stage of the cancer is unclear after completion of a standard diagnostic work-up that includes conventional imaging (CT, MRI, or ultrasound); or
2) The use of the PET could potentially replace one or more conventional imaging study when it is expected that conventional study information is insufficient for the clinical management of the patient; and
3) The clinical management of the client would differ depending on the stage of the cancer identified.

PET Scans
HCPCS codes: G0212, G0215, G0218, G0222
DX: 162.0-162.9, 153.0-154.8, 172.0-172.9, 190.9, 200.00-202.28

385 PET Imaging whole body for re-staging of; lung cancer (non-small cell), colorectal cancer, melanoma, or lymphoma after completion of treatment for **one of the following reasons:**

1) To detect residual disease; or
2) To detect suspected recurrence; or
3) To determine the extent of known recurrence.

PET Scans
HCPCS codes: G0223, G0226

386 PET Imaging whole body or regional to diagnose; head and neck cancer (excluding thyroid and CNS cancers), or esophageal cancer when **at least one of the following is true:**

1) The PET results may assist in avoiding an invasive diagnostic procedure; or
2) The PET results may assist in determining the optimal anatomical location to perform an invasive diagnostic procedure.

PET Scans
HCPCS codes: G0224, G0227
DX: 160-161.9, 170, 170.1, 171.0

387 PET Imaging whole body or regional for initial staging of; head and neck cancer (excluding thyroid and CNS cancers), or esophageal cancer when **at least one of the following is true:**

1) The stage of the cancer is unclear after completion of a standard diagnostic work-up that includes conventional imaging (CT, MRI, or ultrasound); or
2) The use of the PET could potentially replace one or more conventional imaging study when it is expected that conventional study information is insufficient for the clinical management of the patient and
3) The clinical management of the client would differ depending on the stage of the cancer identified.

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Code	Criteria

PET Scans
HCPCS codes: G0225, G0228
DX: 160-161.9, 170, 170.1, 171.0

388 PET Imaging whole body or regional for re-staging of; head and neck cancer (excluding thyroid and CNS cancers), or esophageal cancer after the completion of treatment for **one of the following**:

1) To detect residual disease;
2) To detect suspected recurrence; or
3) To determine the extent of known recurrence.

PET Scans
HCPCS codes: G0229
DX: 345.11, 345.41, 345.54

389 PET Imaging; metabolic brain imaging for pre-surgical evaluation of refractory seizures.

PET Scans
HCPCS codes: G0230
DX: 410.00-414.9

391 PET Imaging; metabolic assessment for myocardial viability when a SPECT study is inconclusive.

PET Scans
HCPCS codes: G0231, G0232, G0233
DX: 153.0-154.8, 200.00-202.28, 202.80-202.88, 172.0-172.9

392 PET WhBD, gamma cameras only, for one of the following reasons:

1) Recurrence of colorectal or colorectal metastatic cancer;
2) Recurrence of melanoma or metastatic melanoma; or
3) Staging and characterization of lymphoma.

PET Scans
HCPCS codes: G0234
DX: 162.0-162.9

393 PET regional or whole body, gamma camera only, when the study is for **one of the following:**

1) A solitary pulmonary nodule following CT; or
2) Initial staging of pathologically diagnosed non-small cell lung cancer.

PET Scans
HCPCS codes: G0253, G0254
DX: 174.0, 175.9

394 PET imaging, for breast cancer, full and partial ring, when the study is for <u>one</u> of the following:

1) Staging/restaging of local regional recurrence or distant metastases, i.e., staging/restaging after, or prior to, course of treatment; or
2) Evaluation of response to treatment, performed during course of treatment.

Medical Admits
CPT: 99221-99223

401 Diagnosis of **<u>Cellulitis</u>** (681-681.9, 682, 682.2-682.9) in a client that received greater than 30 hours of IV antibiotics during the hospitalization and any <u>one</u> of the following:

1) Incision & drainage during admit, <u>or</u>
2) White Count greater than10 on admit, <u>or</u>
3) Persistence or progression of fever, lymphodenopathy, edema, or erythema after a minimum of 24 hours of outpatient antibiotic treatment.

402 Diagnosis of **<u>Abdominal Pain</u>** (789-789.09) in a client with a nasogastric tube and Intravenous fluid administration, during the hospital stay, for greater than 30 hours.

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Code	Criteria
403	Diagnosis of **Dehydration or Electrolyte Imbalances** (276-276.6, 276.8-276.9) in a client with abnormal lab values requiring intravenous electrolyte supplementation, during the hospital stay, for greater than 30 hours.
404	Diagnosis of **Nausea/Vomiting** (536.2; 787-787.03) in a client: 1) With a nasogastric tube and Intravenous fluid administration, during the hospital stay, for greater than 30 hours, or 2) That is unable to tolerate PO and is treated with Intravenous medications, during the hospital stay, for greater than 30 hours
405	Diagnosis of **Gastritis** (535-535.6, 558-558.9) in a client: 1) With a Nasogastric tube and Intravenous fluid administration, during the hospital stay, for greater than 30 hours, or 2) That is unable to tolerate PO and is treated with Intravenous medications, during the hospital stay, for greater than 30 hours.
406	Diagnosis of **headaches** (784.0**,** 346-346.9) in a client receiving Intravenous DHE, during the hospital stay, for greater than 30 hours.
407	Diagnosis of **chronic pancreatitis** (577, 577.1) in a client: 1) With a nasogastric tube and intravenous fluid administration, during the hospital stay, for greater than 30 hours; or 2) That is unable to tolerate PO and is treated with intravenous medications, during the hospital stay, for greater than 30 hours.
408	Diagnosis of **back pain** (724-724.5, 724.8-724.9, 846-847.9) in a client: 1) Failed outpatient treatment; and 2) Continued use of IV pain medication, during the hospital stay, greater than 30 hours; or 3) Continued inability to ambulate after physical therapy intervention greater than 30 hours.
409	Diagnosis of **constipation** (560.3, 560.39, 564-564.9) in a client: 1) Failed outpatient treatment; or 2) Recent abdominal surgery; and 3) Extensive inpatient treatment, during the hospital stay, greater than 30 hours.
Other Inpatient Medical Admits	
420	Inpatient medical admits requiring expedited prior authorization and not meeting expedited criteria, but medically necessary/medically appropriate in accordance with established criteria, for continued stay over 24 hours. Medical appropriateness must be clearly evident by the documentation in the client's medical record.
Visual Exams	
CPT: 92014-92015	
610	**Eye Exam** within two (2) years of last exam when no medical indication exists and **both** of the following are documented in the client's record: 1) Glasses or contacts are broken or lost; **and** 2) Last exam was 18 months ago or longer.

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Code	Criteria	Code	Criteria

Dispensing/Fitting Fees For Glasses
CPT: 92340-92342

615 **Glasses (both frames and lenses)** within two (2) years of last dispense may be replaced when glasses are broken or lost and **all** of the following are documented in the client's record:

1) Copy of current prescription (must not be older than 17 months); **and**
2) Date of last dispense; **and**
3) Both frames and lenses are broken or lost.

Dispensing/Fitting Fees For Frames Only
CPT: 92340

618 **Frames Only** within two (2) years of last dispense may be replaced when frames only are broken, and all of the following are documented in the client's record:

1) No longer covered under the manufacturer's one (1) year warranty; **and**
2) Copy of current prescription demonstrating the need for prescription eye wear; **and**
3) Documentation of frame damage.

619 **Durable Frames (American Athletic or Invincible)** when **one** of the following is documented in the client's record:

1) Client has a seizure disorder that results in frequent falls; **or**
2) Client has a history of two or more incidences of broken frames in the past 12 months as a result of a medical condition.

620 **Flexible Frame (Daryl or Scott)** when **one** of the following is documented in the client's record:

1) Client has a seizure disorder that results in frequent falls; **or**
2) Client has a history of two or more incidences of broken frames in the past 12 months as a result of a medical condition.

Dispensing/Fitting Fees For Lenses Only
CPT: 92341, 94342

623 **Lenses Only** within two (2) years of last dispense when the lenses only are lost or broken and **all** of the following are documented in the client's record:

1) Copy of current prescription (prescription must not be older than 17 months); **and**
2) Date of last dispense; **and**
3) Documentation of lens damage or loss.

624 **Lenses Only** within two (2) years of last dispense, for refractive changes (provider error is the responsibility of the provider to warranty their work and replace the lenses at no charge) when **all** of the following are documented in the client's record:

1) Copy of current prescription (prescription must not be older than 17 months); **and**
2) Date of last dispense; **and**
3) The current exam shows a refractive change of .75 diopters or more; **and**
4) The client has headaches, blurred vision, difficulty with school or work and it has been diagnosed by a physician as caused from the inability to see adequately; **and**
5) The client does not have a medical condition that is known to cause temporary visual acuity changes (e.g. diabetes, pregnancy).

Note: In conditions other than pregnancy, if vision has been stable for 3 months and medical condition is stable, lenses are allowed when (1)-(4) previously listed are true.

625 **High Index Lenses** when **one** of the following is documented in the client's record:

1) Spherical correction is greater than, or equal to, +\- 8 diopters; **or**
2) Cylinder correction is greater than, or equal, to +\- 3 diopters.

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Code	Criteria	Code	Criteria

626 **Executive bifocals and trifocals** for clients 11 years of age and older, with a diagnosis of accommodative esotropia or strabismus documented in the client's record.

Dispensing|Fitting Fees For Contacts

STATE-UNIQUE CODES: 9275M, 9276M, or 9277M

627 **Contacts (client must meet criteria found in MAA's Vision Care Billing Instructions for contacts)** within one (1) year of last dispense may be replaced when contacts are broken or lost and **both** of the following are documented in the client's record:

1) Copy of current prescription (must not be older than 17 months) **and**
2) Date of last dispense documented.

Blepharoplasties

CPT: 67901-67908

630 Blepharoplasty for noncosmetic reasons when both of the following are true:

1) The excess upper eyelid skin impairs the vision by blocking the superior visual field; and
2) On a central visual field test, the vision is blocked to within 10 degrees of central fixation.

Strabismus Surgery

CPT: 67311-67340

631 Strabismus surgery for clients 18 years of age and older when both of the following are true:

1) The client has double vision; and
2) It is not done for cosmetic reasons.

Physical Therapy

CPT: 97010-97150, 97520-97537,97750

640 **An additional 48 Physical Therapy program units** when the client has already used the allowed program units for the current year and has **one** of the following surgeries or injuries:

1) Lower Extremity Joint Surgery;
2) CVA not requiring acute inpatient rehabilitation; or
3) Spine surgery.

641 **An additional 96 Physical Therapy program units** when the client has already used the allowed program units for the current year and has recently completed an acute inpatient rehabilitation stay.

Occupational Therapy

CPT: 97110, 97112, 97520, 97530, 97532, 97533, 97535, 97537

644 **An additional 12 Occupational Therapy** visits when the client has used the allowed visits for the current year and has **one** of the following:

1) Hand\Upper Extremity Joint Surgery; or
2) CVA not requiring acute inpatient rehabilitation.

645 **An additional 24 Occupational Therapy** visits when the client has already used the allowed visits for the current year and has recently completed an acute inpatient rehabilitation stay.

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MAA-Approved Centers of Excellence (COE)

[Refer to WAC 388-531-0650 and WAC 388-531-0700]

The following services must be performed in an MAA-approved Center of Excellence (COE) and **do not require authorizations**. See next page for a list of COEs.

- ✓ Organ/bone marrow/peripheral stem cell transplants;
- ✓ Inpatient Chronic Pain Management (0088M-0099M);
- ✓ Sleep studies (CPT codes 95805, 95807-95811) only allowed for ICD-9 Diagnosis 780.51, 780.53, 780.57, or 347;
- ✓ Weight Loss Program.

Note: When billing hard copy, note the COE in Box 32 on the HCFA-1500 claim form or in the *Comments* field when billing electronically.

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MAA-Approved Organ Transplant Centers of Excellence (COE)

APPROVED TRANSPLANT HOSPITALS	ORGAN(S)	CPT CODE
Children's Hospital & Medical Center/Seattle	• Bone Marrow (BMT) (autologous & allogenic) • Peripheral Stem Cell Transplant (PSC-T) • Heart • Liver • Kidney	• 38230, 38240-38241 • 38231, 38240-38241 • 33945 • 47135-47136 • 50360, 50365, 50380
Dorenbacher Children's Hospital/Portland **NW Marrow Transplant Program (PSC-T only)**	• BMT • PSC-T	• 38230, 38240-38241 • 38231, 38240-38241
Fred Hutchinson Cancer Research Center/Seattle	• BMT • PSC-T	• 38230, 38240-38241 • 38231, 38240-38241
Good Samaritan Hospital Medical/Puyallup	• PSC-T	• 38231, 38240-38241
Inland NW Blood Center	• PSC-T	• 38231, 38240-38241
Legacy Good Samaritan Hospital/Portland **(Northwest Marrow Transplant Program)**	• BMT • PSC-T	• 38230, 38240-38241 • 38231, 38240-38241
Mary Bridge Children's Hospital/Seattle	• PSC-T (autologous only)	• 38231, 38241
Oregon Health Sciences University (OHSU)/Portland	• Heart • Liver • Kidney • Pancreas	• 33945 • 47135-47136 • 50360, 50365, 50380 • 48160, 48554
Providence St. Peter Hospital/Olympia	• PSC-T	• 38231, 38240-38241
Sacred Heart Medical Center/Spokane	• Kidney • Heart • Heart/Lung(s) • Lung	• 50360, 50365, 50380 • 33945 • 33935 • 32851-32854
Seattle Cancer Care Alliance/Seattle	• BMT • PSC-T	• 38230, 38240-38241 • 38231, 38240-38241
St. Joseph's Hospital/Tacoma	• BMT (autologous only) • PSC-T	• 38230, 38241 • 38231, 38240-38241

[*Refer to WAC 388-531-1750 and WAC 388-550-2000]

MAA-Approved Organ Transplant Centers of Excellence (COE) (Cont.)

APPROVED TRANSPLANT HOSPITALS	ORGAN(S)	CPT CODE
Swedish Medical Center/Seattle	• Kidney • PSC-T	• 50360, 50365, 50380 • 38231, 38240-38241
University of Washington Medical Center/Seattle	• BMT • PSC-T • Heart • Heart/Lung(s) • Lung • Kidney • Liver • Pancreas	• 38230, 38240-38241 • 38231, 38240-38241 • 33945 • 33935 • 32851-32854 • 50360, 50365, 50380 • 47135-47136 • 48160, 48554
Virginia Mason Hospital/Seattle	• Kidney • Pancreas • BMT • PSC-T	• 50360, 50365, 50380 • 48160, 48554 • 38230, 38240-38241 • 38231, 38240-38241

[*Refer to WAC 388-531-1750 and WAC 388-550-2000]

MAA-Approved Sleep Centers

MAA Approved Sleep Centers	Location
ARMC Sleep Apnea Laboratory	Auburn Regional Medical Center: Auburn, WA
Columbia Sleep Laboratory	Richland, WA
Diagnostic Sleep Disorder Program Center	Children's Hospital and Medical: Seattle, WA
Good Samaritan Hospital ***(Effective for dates of service on and after 10/1/02 - no longer an MAA-Approved Sleep Center.)***	Puyallup, WA
Highline Sleep Disorders Center	Highline Community Hospital: Seatttle, WA
Kathryn Severyns Dement Sleep Disorders Center	St. Mary's Medical Center: Walla Walla, WA
Multi Care Sleep Disorders Center	Tacoma General Hospital/Mary Bridge Children's Hospital: Tacoma, WA
Providence Everett Medical Center Sleep Disorder Center	Providence General Medical Center: Everett, WA
Richland Sleep Lab ***(Effective for dates of service on and after 10/1/02 - no longer an MAA-Approved Sleep Center.)***	Richland, WA
Sleep Center at Valley	Valley Medical Center: Renton, WA
Sleep Center for Southwest Washington	Providence St. Peter: Olympia, WA
Sleep Disorder Center of Central Washington	Providence Medical Center: Yakima, WA
Sleep Disorder Center Virginia Mason Hospital	Virginia Mason Hospital: Seattle, WA
Sleep Disorders Center Legacy Good Samaritan Hospital and Medical Center	Legacy Good Samaritan Hospital and Medical Center: Portland, OR
Sleep Related Breathing Disorders Laboratory St Clare Hospital	St. Clare Hospital: Tacoma, WA
Sleep Studies Laboratory Mid Columbia Medical Center	Mid Columbia Medical Center: Dalles, OR
St. Joseph Regional Medical Center Sleep Lab	St. Joseph Regional Medical Center: Lewiston, ID
Swedish Sleep Medicine Institute	Providence Swedish **or** Swedish First Hill: Seattle, WA
The Sleep Institute of Spokane	Sacred Heart Medical Center **or** 104 W. 5th Suite 400 W: Spokane, WA
University of Washington Sleep Disorders Center\Harborview Medical Center	Harborview Medical Center: Seattle, WA

[Refer to WAC 388-531-1500]

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Physicians must:

- Use CPT procedure codes 95805, 95807-95811 for sleep study services.
- Enter the location of the approved sleep center where the sleep study/ polysomnogram or multiple sleep latency testing was performed. (Refer to previous page for appropriate location of MAA-approved sleep center.)
- When billing electronically, enter the information into the *Comments* field. If you are billing hard copy, enter the information in field 32 on the HCFA-1500 claim form.
- All sleep studies are limited to Obstructive Sleep Apnea, ICD-9-CM diagnosis codes **780.51, 780.53, 780.57**; or Narcolepsy **347**.

MAA-Approved Inpatient Pain Clinics

MAA-Approved Inpatient Pain Clinic
St. Joseph Hospital & Health Care Center, Tacoma

MAA-Approved Weight Loss Program

MAA-Approved Weight Loss Program
MAA encourages any providers who have structured weight loss programs and would like to be included as an MAA approved facility [refer to WAC 388-531-1600] to send their program criteria and credentials to: MAA ATTN: Dr. Joan Baumgartner PO Box 45500 Olympia, WA 98504-5500

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